UNPUBLISHED

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF IOWA
CENTRAL DIVISION

CYNTHIA KROWIORZ, Plaintiff, vs. JO ANNE B. BARNHART, Commissioner of Social Security, Defendant.	No. C04-3032-MWB **REPORT AND RECOMMENDATION**

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I. INTRODUCTION

The plaintiff Cynthia Krowiorz ("Krowiorz") appeals a decision by an administrative law judge ("ALJ") denying her applications for Title II disability insurance ("DI") and Title XVI supplemental security income ("SSI") benefits. Krowiorz claims the ALJ erred in evaluating her credibility, posing an improper hypothetical question to the Vocational Expert, determining her residual functional capacity, and discounting the opinions of her treating physician. (*See* Doc. No. 7)

II. PROCEDURAL AND FACTUAL BACKGROUND

A. Procedural Background

On June 20, 2001, Krowiorz filed applications for DI and SSI benefits, alleging a disability onset date of August 16, 2000. (R. 59-61, 291-93[1]). Krowiorz alleged she was disabled due to degenerative joint disease, high blood pressure, obstructive lung disease, and severe back pain. (*See* R. 79) Her applications were denied initially on December

[1]On Krowiorz's SSI application, her disability onset date is typewritten as January 1, 1995, with the August 16, 2000, date handwritten immediately underneath the January date. *See* R. 291. The court assumes the January 1995 date was simply an error.

27, 2001. (R. 45, 47-50, 294). Krowiorz filed a request for reconsideration in which she indicated her condition continued to worsen, and she was not able to care for herself and her home, "let alone being able to work at a job and support [herself]." (R. 52) Her applications were denied upon reconsideration on June 12, 2002. (R. 46, 54-57, 295)

On June 24, 2002, Krowiorz requested a hearing, stating she was unable to work because of severe pain in her back and legs. (R. 58) A hearing was held before ALJ Jean M. Ingrassia on February 6, 2003, in West Des Moines, Iowa. (R. 320-60) Krowiorz was represented at the hearing by attorney Ronald Wagenaar. Krowiorz testified at the hearing, as did her daughter, Heidi Grant. Vocational Expert ("VE") Roger Marquardt also testified at the hearing.

On May 28, 2003, the ALJ ruled Krowiorz was not entitled to benefits. (R. 23-37) Krowiorz appealed the ALJ's ruling, and on February 13, 2004, the Appeals Council, after reviewing some additional medical evidence and argument (*see* R. 11-19), denied Krowiorz's request for review (R. 7-10), making the ALJ's decision the final decision of the Commissioner.

Krowiorz filed a timely Complaint in this court on April 8, 2004, seeking judicial review of the ALJ's ruling. (Doc. No. 3) In accordance with Administrative Order #1447, dated September 20, 1999, this matter was referred to the undersigned United States Magistrate Judge pursuant to 28 U.S.C. § 636(b)(1)(B), for the filing of a report and recommended disposition of Krowiorz's claim. Krowiorz filed a brief supporting her claim on July 20, 2004. (Doc. No. 7) The Commissioner filed a responsive brief on September 17, 2004 (Doc. No. 8).

The matter is now fully submitted, and pursuant to 42 U.S.C. § 405(g), the court turns to a review of Krowiorz's claim for benefits.

B. Factual Background

1. Introductory facts and Krowiorz's hearing testimony

At the time of the hearing, Krowiorz was fifty-six years old. She was 5'5" tall and weighed 180 pounds, which she stated was a fairly normal weight for her. She completed high school, and later took some courses and became a certified nurse's aide in 1987, and a certified medication aide in 1993. (R. 324)

Krowiorz stated she has minor problems concentrating because her mind will wander a bit, but "nothing major." (*Id.*) She has no problems with reading, spelling, or understanding and remember things. (*Id.*)

Krowiorz stated she is prevented from working due to back and leg pain. Her back pain is all the way across her lower back, radiating down into her legs. She described her back pain as a sharp pain, but notes it also feels "like a big heavy weight on [her] back, pushing down." (R. 325) The pain started bothering her a lot in 2000 or 2001. Prior to that time, she was having problems with back pain, but it was not severe enough to keep her from working. She stated the pain is always present. She gets some relief from Methadone, but nothing makes the pain go away completely. Activity makes the pain worse. She is unable to vacuum the floor, and walking aggravates the pain. (R. 325-26)

Krowiorz indicated she was taking Methadone daily for pain, 40 mg in the morning and 50 mg at night. The drug had been prescribed by Mark D. Johnson, M.D. She had been on the medication for a couple of years at the time of the hearing. Prior to taking Methadone, she had taken MS Contin, which helped about the same but was much more expensive. (R. 326-327) She acknowledged that she had abused prescription medications in the past, but according to her, she and her doctor had reached an agreement regarding her dosage and she now takes her medications exactly as prescribed. (R. 343-44) She stated she takes the Methadone, which is a narcotic, because other types of pain medica-

tions have not worked. (R. 344) In response to the ALJ's questioning about the lack of any definitive diagnosis in the record regarding her back problem, Krowiorz stated she had not had an MRI due to lack of funds. According to Krowiorz, Dr. Johnson thinks her pain is due to a sciatic nerve problem. (*Id.*) Krowiorz stated an X-ray is insufficient because it will not show nerve damage, but the ALJ indicated she could not order an MRI on Social Security's behalf "because Social Security won't pay for one." (R. 345)

Krowiorz also described problems with leg pain. She stated she gets "real sharp pains that start in [her] butt, and go[] all the way down [her] leg." (R. 327) When the pain is worst, she has problems even trying to sit down, and even small movements are very painful. She experiences intermittent pain in both legs, but not in both legs at the same time. According to Krowiorz, her doctor has told her the leg pain also is from her sciatic nerve. She has the severe leg pain every few weeks, and it may last for as long as a month at a time. During these periods, her doctor increases her Methadone dosage. She also has tried Prednisone, but it made her sick. Walking aggravates her leg pain. She stated the pain usually starts in her calf area and then always gets worse. She had been having the leg pain for about a year at the time of the hearing. (R. 327-38)

Krowiorz stated she can stand for ten to fifteen minutes before the pain in her lower back and leg gets so bad that she has to sit down. She can sit about the same length of time, but can sit longer if she can change positions. She stated she can walk half a block to a block at a time before she must stop due to pain in her back and legs. She is able to bend, but prefers not to because it hurts. She does not kneel because she believes she would be unable to get back up unassisted. She can open a door, but cannot push/pull as required to vacuum. She has no limitations on using her fingers and hands. She can lift a gallon of milk using one hand, and can lift a small bag of groceries, but she does not lift anything very heavy. Her grandchildren will sit in her lap, but she does not lift them.

She opined she could lift a gallon of milk several times during an hour. She can climb stairs slowly, one step at a time, if there is a railing she can use for support. (R. 330-31)

Krowiorz stated she suffers from depression, for which she takes Lexapro, also prescribed by Dr. Johnson. She stated she gets depressed because of her physical limitations. She also stated she gets "real anxious" if she is around other people, and she likes to be alone. She does not associate much outside her family circle, and she even gets impatient and nervous around her family after a few minutes. (R. 331-32)

Krowiorz stated she has no memory problems, and no problems handling or counting money. She is able to shower, put on her own shoes, dress herself, and feed herself. She does not take baths because she fears she would be unable to get out of the tub due to her pain. She noted she sees Dr. Johnson "[e]very couple of months," and she had been seeing him for about seven years. (R. 332-33)

In addition to the Methadone and Lexapro, Krowiorz indicated she was taking Acupril 40 mg daily, Tiazac 420 mg daily, and Hydrochlorothiazide, all for high blood pressure. According to Krowiorz, she takes all of these medications as prescribed. (R. 333-34)

Krowiorz described her typical day. She stated she gets up about 4:30 a.m. because she likes early mornings. She has coffee and watches the news. Then, because her daughter leaves early for work, Krowiorz drives down to her daughter's house a few blocks away and wakes up her fourteen-year-old grandson for school. (She cannot call to awaken her grandson because she does not have a phone. R. 351) She returns home and spends the day reading and watching television. She will watch TV for ten to fifteen minutes at a time, and then get up and move around for awhile. She stated she changes positions "all the time." (R. 334)

As far as housework, she might do some light dusting or rinse out a few dishes. She noted she does not cook much, usually heating things up in the microwave or eating cereal and yogurt, so she does not have many dishes to do. Her daughter does her vacuuming, laundry, and other heavy chores. Krowiorz stated she is unable to do her own laundry because it involves too much bending over, but she can sit and fold clothes. She lives in a small apartment, so she has no yard work to do. Her apartment consists of a small living room, a galley kitchen, a bedroom, and a bathroom. (R. 334-35, 343)

Krowiorz stated she does not belong to any social groups, clubs, or church groups. She lives right across the street from Hy-Vee, so she buys small amounts of groceries at a time, just whatever she might need for a day. She stated she does not buy large amounts of groceries at one time because she would not want to walk around the store that long. (R. 336) Krowiorz noted she performs all of her activities a lot more slowly than she used to. She stated she used to be "a pretty active person," but she can only maintain a slow pace now because it is too painful when she moves faster. (*Id.*)

Krowiorz's attorney noted she had shifted positions during the hearing. Krowiorz stated her hip was hurting. She noted the type of chair in which she sits makes little difference in her pain; she has to move around whenever she sits in one position for too long regardless of the type of chair. She stated she does drive a car for short distances, just locally around town in Mason City, Iowa. She has a car with an automatic transmission, and she has no trouble driving. She also has no problems with environmental conditions, including changes in temperature. (R. 336-37)

Krowiorz stated she used to have problems with headaches, but she no longer gets headaches very often. She indicated she becomes short of breath quickly, and she acknowledged she smokes cigarettes. She stated she has tried to quit smoking, without success. She noted her breathing problems would not affect her ability to work. (R. 338)

Regarding her work history, Krowiorz stated she worked as a housekeeper at a Day's Inn in 2001. She cleaned rooms, made the beds, cleaned the bathrooms, dusted the furniture, and vacuumed. She stated all of these tasks had to be done quickly. She worked twelve to fifteen hours a week in that job, which she held from April 18 to June 11, 2000. (*See* R. 93) She quit because the bending, moving around, hauling the cleaning cart from room to room, and other duties hurt her back. (R. 93, 338-39)

Krowiorz worked as an aide at Homestead Assisted Living in Mason City, Iowa, from December 14, 2000, to April 15, 2001. She worked about twelve hours per week helping residents bathe, giving them their medications, and helping them with other tasks they could not do on their own. She stated she quit the job because the bending and other physical requirements were too hard. (R. 93, 339) In her work history form, she also stated she was having difficulty working at night because she kept falling asleep. (R. 93)

Krowiorz worked as a nurse's aide at the IOOF nursing home from January 19, 1999, to August 16, 2000. She averaged thirty-two hours per week. She took an extended leave of absence due to hysterectomy surgery, and according to Krowiorz, when she tried to return, there was no longer a position available for her. (R. 93) She indicated the job duties as a nurse's aide were very difficult. There was a lot of lifting and repositioning of patients who could not get up and move around by themselves. She also helped patients bathe, dress, and perform all of their other physical activities. She indicated she worked at that job before her back pain became really bad. According to Krowiorz, a nurse at the facility suggested she should not be doing that type of work. (R. 339-40)

Krowiorz stated she also has worked at various food service jobs. She worked as a "prep person" at Hardy's. She stated she would butter bread, chop lettuce, transfer boxes from the freezer to the cooler, weigh meat, and work at the counter. She worked

at McDonald's, where she cooked and worked at the counter. Both of those jobs were before she began experiencing problems with her back and legs. (R. 340-41) Due to the amount of standing involved and the fast pace of the jobs, she does not believe she could return to that type of work. (R. 341)

Krowiorz indicated she never had to use a computer in any of her jobs. When she would administer medications, she made handwritten notes on the patient's chart. (R. 352)

At the time of the hearing, Krowiorz was living alone. She indicated she previously lived with her daughter, Heidi Grant, for about a year, but Krowiorz moved out on July 1, 2002, because HUD indicated they could get her an apartment, and she and her daughter both wanted more privacy. According to Krowiorz, since she began living alone, her rent has been paid by HUD and she receives food stamps. She has no sources of income. She indicated her daughters help her out with gas money and necessities, but otherwise, her needs are few and she will "just go without." She receives some type of public assistance in obtaining her prescription medications. She also has borrowed money from both of her daughters and her mother. (R. 341-43)

2. Heidi Grant's hearing testimony

Heidi Grant stated she is Krowiorz's daughter. According to Grant, Krowiorz lived with Grant and her family for some period of time, and Grant has continued to see her mother daily since her mother moved into her own apartment. Grant stated she does her mother's laundry and vacuuming, and helps her with other tasks. According to Grant, Krowiorz is unable to lift much of anything, and she has difficulty even walking. She stated her mother grunts when she walks due to the pain she experiences. Grant stated she has three steps leading into her kitchen, and her mother is unable to climb the

steps unless she pulls herself along using a railing. She noted her mother can only sit for a short time before she has to get up and walk around.

Grant also stated her mother walks very slowly. In Grant's opinion, her mother's condition has worsened over time. She stated Krowiorz used to take walks and do things with Grant's daughter, but she is no longer able to do those things.

Grant stated Krowiorz sometimes is irritable with Grant's husband, and Krowiorz can be short with her grandchildren and others. (R. 346-49)

3. Krowiorz's medical history

a. Respiratory problems

One of Krowiorz's alleged causes of disability is respiratory/breathing problems. The record indicates Krowiorz has sought treatment relating to respiratory problems since at least March 1999, when she was seen in the emergency room at North Iowa Mercy Health Center, complaining of a worsening cough. She was diagnosed with an upper respiratory tract infection with sinusitis, and bronchitis. Doctors prescribed antibiotics, cough suppressants, and fluids. It was noted that Krowiorz was a smoker, and she stated she had attempted to cut down on her smoking. (R. 132)

Krowiorz returned to the emergency room twice in May 1999, for problems related to labored breathing, cough, chronic hoarseness, and a burning sensation in the back of her throat. Chest X-rays were negative. She was treated with antibiotics, an Albuterol inhaler, and a cough medication. Doctors opined her chronic hoarseness might be related to reflux, and they advised her to follow up with Dr. Johnson. (R. 134-37)

Other than doctors' notations about Krowiorz's smoking, and recommendations that she quit smoking (*see* R. 188, 194-95), there is no indication she had further respiratory complaints until March 15, 2000, when she went to the emergency room

complaining of a dry cough for several days and right-sided chest pain, worse when she coughed. She was diagnosed with bronchitis and costochondritis. She was treated with antibiotics, Tylenol #3 for pain, and was placed on a lifting restriction for work. (R. 149)

She returned to the emergency room on June 30, 2000, complaining of a cough and shortness of breath. Doctors prescribed antibiotics, Flovent inhaler, and cough syrup, and counseled her about the connection between smoking and bronchitis. (R. 157-58) Ten days later, her cough had not improved and she reported difficulty sleeping at night due to the cough. She was diagnosed with bronchitis and her prescription for antibiotics was refilled. She also received a prescription for a cough suppressant. (R. 187) Krowiorz returned to the doctor four days later seeking a refill of the cough medicine, but the doctor declined and told her to try over-the-counter Robitussin. (R. 185)

Krowiorz was seen on November 16, 2000, complaining of a nonproductive cough and nasal drainage for three days. She was diagnosed with an upper respiratory infection and possible sinusitis. Patrick D. Dunley, D.O. prescribed an antibiotic, antihistamine, nasal spray, mouth rinses, and cough suppressant. (R. 178-79) Krowiorz requested a refill of the cough suppressant on November 20, 2000, but the doctor declined and advised her to try an over-the-counter product. (R. 177)

Krowiorz went to the emergency room on December 8, 2000, again complaining of a nonproductive cough. She indicated she had "visited the emergency room approximately six times in the last two months for cough" (R. 166); however, the record does not support this assertion. She stated the cough bothered her the most at night. She indicated she was still smoking. Doctors diagnosed a chronic cough. Because Krowiorz stated she had obtained some relief from an Albuterol inhaler, the doctor elected to prescribe an inhaler instead of the codeine cough suppressant Krowiorz requested. (*Id*.)

At a follow-up visit relating to her hypertension on January 15, 2001, doctor's notes indicate Krowiorz had chronic obstructive pulmonary disease and was still experiencing an early morning cough. Dr. Mark Johnson noted Krowiorz was "still unable or unwilling to practice smoking cessation," which he continued to urge. (R. 172-73)

On February 5, 2001, Krowiorz saw Bruce Harlan, M.D. regarding her chronic cough. She stated she was trying to quit smoking and was down to seven cigarettes per day. She reported mild shortness of breath. Dr. Harlan diagnosed her with acute bronchitis and chronic obstructive pulmonary disease. He prescribed an antibiotic, cough suppressant, and smoking cessation. (R. 169)

The record indicates that as of December 2002, Krowiorz was smoking "exactly seven cigarettes per day." (R. 281)

The record contains no further medical evidence of Krowiorz's respiratory problems.

b. Hypertension

Krowiorz also alleges she is disabled due to hypertension. (*See* R. 79) On December 29, 1999, she was seen in the emergency room complaining of elevated blood pressure and headache. She reported a twenty-year history of hypertension and recent difficulty controlling her blood pressure ("BP"). She stated she checked her blood pressure every morning with a wrist cuff, and she stated her BP prior to going to the ER was 200/150. During her visit, her BP fluctuated between 166/100 and 192/122. Doctors treated her headache, and her BP came down, although it was still abnormally high. Doctors opined her headache had contributed to her elevated BP, as she had no focal neurological symptoms or other significant findings to explain her headache. Doctors

directed Krowiorz to continue her current dose of Accupril 80 mg and Adalat 60 mg, and they added 12.5 mg of hydrochlorothiazide. She was directed to return to the ER the next day for a recheck of her BP, and to follow up with Phillip Alscher, M.D., with whom she already had scheduled an appointment. (R. 146)

Krowiorz saw Dr. Alscher on January 4, 2000, for evaluation of resistant hypertension. Krowiorz stated she sometimes could not get her medications due to lack of funds, and the doctor suspected her uncontrolled hypertension was due to medication non-adherence. However, he also noted she was a smoker, and she reported a significant family history of hypertension, with both her mother and her daughter suffering from hypertension. Dr. Alscher encouraged Krowiorz to stay on her medications, and he gave her some samples of Accupril. In addition, he ordered a renal ultrasound with Doppler's to rule out renovascular disease. He directed her to return for follow-up in two weeks. The doctor declined Krowiorz's request for some samples of Ultram. (R. 194-95)

Krowiorz's renal ultrasound indicated potential arterial stenosis in her left kidney and a possible small cyst or other mass in her right kidney. (R. 193, 200) The radiologist recommended a follow-up renal angiogram. (*Id.*) Dr. Alscher discussed the findings with Krowiorz, and scheduled her for a renal angiogram with possible angioplasty and stent placement. (R. 192) The angiogram was performed on January 19, 2000, revealing significant left upper renal artery stenosis and fibromuscular dysplasia. She underwent an angioplasty. It appears a stent was placed (*see* R. 175, 188), although the record is somewhat unclear on this point (*see* R. 192). Her Adalat and Accupril were discontinued, and she was put on Thiazide 50 mg daily. Krowiorz reported feeling great and having no symptoms. (R. 188, 197) Dr. Alscher noted Krowiorz's hypertension still needed to be under better control. He resumed her Accupril at 40 mg daily and continued

the Thiazide. He recommended she quit smoking, noting she could have complications of her iliac disease and renovascular disease if she continued to smoke. (R. 188)

A year later on January 2, 2001, Krowiorz returned to see Dr. Alscher for follow-up of her hypertension. She stated she had stopped taking Accupril in December 2000, because, according to Krowiorz, an ER doctor said the Accupril could hurt her kidneys. She was given a prescription for Atenolol but she did not fill it. Dr. Alscher restarted her on Accupril 40 mg. He advised her to take her medications as directed and not to make changes unless she talked to him. He again recommended she quit smoking. (R. 174-75)

Krowiorz returned to the clinic for follow-up on January 15, 2001, this time seeing Mark Johnson, M.D. Krowiorz's BP was elevated at 148/90, but she had run out of Adalat and had not taken it that day. Dr. Johnson deferred to Dr. Alscher's orders regarding continued treatment of Krowiorz's hypertension. (R. 172-73)

On June 21, 2001, Dr. Johnson noted Krowiorz's Accupril dosage had been reduced from 40 mg to 20 mg daily because her blood pressure had been less than 100 systolic. He noted she was still smoking half a pack of cigarettes daily. (R. 215)

At a follow-up appointment for her back pain on August 23, 2001, Dr. Johnson noted Krowiorz's blood pressure was under reasonable control. She experienced some lightheadedness during warm weather but the condition resolved in cooler weather. Her BP upon examination was 112/70. (R. 211)

On December 5, 2002, at a follow-up appointment regarding her chronic back pain, Dr. Johnson noted Krowiorz's BP was elevated at 162/100, but he also noted she was in pain. (R. 282) At her next appointment on December 16, 2002, her BP was 134/76. (R. 281)

The record does not contain further medical evidence of problems controlling Krowiorz's hypertension, which appears to have remained under control on medication. (*See, e.g.*, R. 281)

c. Degenerative joint disease; severe back pain

As evidenced by Krowiorz's testimony and her medical records, her primary allegation of disability relates to ongoing back pain. Although her alleged disability onset date is August 15, 2000, the first indication the court has found in the record relating to her back pain is a note by Mark C. Johnson, M.D. at a general follow-up visit on January 15, 2001, in which he stated Krowiorz's "back pain continues to plague her intermittently." (R. 172) In the doctor's impression notes from that visit, he included the following: "Chronic debilitating back pain. She continues to use ULTRAM intermittently. I suggested she not use it more than three or four times per week." (R. 173) It is not clear when or by whom Krowiorz was prescribed Ultram for her back pain, although there is one record note that she asked Dr. Alscher for some Ultram samples on January 4, 2000. (*See* R. 195)

On May 14, 2001, Dr. Johnson wrote an opinion letter at Krowiorz's request, in which he offered the following opinion regarding her medical problems:

> This woman has a history of renal artery stenosis status post angioplasty.
>
> Other medical problems that impair her include debilitating back pain. Finally, she has had long-standing hypertension and does carry the diagnosis of obstructive lung disease.
>
> Most of her debility is on the basis of her back pain. Conversations with her on May 14 document that even a few hours of work that require standing or bending and stooping have not been tolerated because of back pain. She has a diagnosis

> of degenerative arthritis of the back with chronic low back strain. She has tried conservative measures with exercise, therapy and medications without success.

(R. 202) The record does not contain evidence of the "diagnosis of degenerative arthritis of the back with chronic low back strain," or of the treatment methodologies the doctor mentioned that Krowiorz had attempted.

On June 4, 2001, doctor's notes indicate Krowiorz had been given samples of Celebrex, but she had not received any relief from the medication. It is not clear when she received these samples. She requested return to Ultram, which Dr. Johnson prescribed at a maximum of three per week. Notes indicate the prescription had to last her for two months because she was "a drug abuser." (R. 216)

Krowiorz went to the ER on June 6, 2001, complaining of chest and side pain after a fall. She was diagnosed with a chest contusion and was given a prescription for Ultram. (R. 203-06)

Krowiorz returned to see Dr. Johnson for follow-up of her chronic back pain on June 21, 2001. He noted she had abused narcotics in the past, and she was requesting Ultram again. He placed her on a regiment of Ultram 50 mg two to three times per week, and gave her a three-month prescription (forty-eight tablets).

On July 16, 2001, Krowiorz requested more samples of Ultram. Office notes indicate her request was declined because she was given a three-month prescription on June 21, 2001. (R. 214) She returned on August 16, 2001, again requesting Ultram samples. Her request again was declined, and she made an appointment with Dr. Johnson to discuss the matter. (R. 213) She saw Dr. Johnson on August 23, 2001, for follow-up of her "continued and chronic back pain." (R. 211) The doctor noted Krowiorz had "had chronic back pain for many years," and she had "used drugs inappropriately for some time, accessing both Lortab and Ultram from multiple providers

in the community," as well as at times getting "benzodiazepines including Xanax." (R. 211) Dr. Johnson noted Krowiorz had filed a disability application due to her chronic back pain which had "been a consistent complaint for many years and is debilitating for her." (*Id.*) He reached the following conclusions regarding her continued care:

> After discussing the options and this patient's situation, it is quite clear this woman is going to have chronic pain. I think it would be best for her to use a drug that is long acting, cannot be abused easily and hopefully can control her pain better. I suggested we start her with low-dose MS CONTIN. . . . I will recheck in approximately two weeks. . . . I also cautioned her if she accesses any narcotic analgesia through any other provider, not only would I terminate any narcotics from this provider but I would also terminate her care and she would need to find another provider.

(R. 212) He started her on 15 mg of MS Contin daily, and continued the Ultram 50 mg as needed for the first three weeks until she attained steady levels of the MS Contin.[2] (*Id.*)

On September 4, 2001, Krowiorz called Dr. Johnson to report she was still having pain "and breaking through." (R. 217) He increased her MS Contin dosage to 30 mg nightly. (*Id.*)

Dr. Johnson saw Krowiorz again on February 11, 2002, for follow-up and to provide an opinion in connection with her application for reconsideration of denial of Social Security benefits. The doctor offered the following opinion about Krowiorz's condition:

> Cynthia has trouble with activities of daily living including food preparation, laundry and simple housecleaning tasks. Cynthia also has problems with sleep disturbance. Her back

[2]MS Contin is a brand name for morphine sulfate. *See* rxlist.com, MS Contin.

> pain is so severe that she is required to sleep in positions that prevent her lower extremities from becoming numb. Cynthia is unable to work as her back pain is so debilitating that the simple acts of sitting and standing prevent her from most occupational descriptions. Cynthia requires daily MS Contin to be able to function.

(R. 244)

On June 10, 2002, Krowiorz underwent an ultrasound of her left leg to rule out deep venous thrombosis. No sonographic evidence of DVT was found. (R. 278)

Dr. Johnson saw Krowiorz again on September 5, 2002. At that time, she reported "pain in her left low back radiating down into the left buttock." (R. 289) Her symptoms had just begun that day, and Krowiorz opined she had aggravated her condition by going for a walk. She stated her leg felt weak. Dr. Johnson noted Krowiorz was taking Methadone 10 mg four times daily for pain. The record does not indicate when he changed her medication from the MS Contin to Methadone. Upon examination, Dr. Johnson noted Krowiorz walked with a limp, favoring her left leg. When she sat in a chair, her left buttock was off the chair and her weight was mainly on her right buttock. Straight-leg-raising test was negative, deep tendon reflexes were 2 + bilaterally, and she exhibited full dorsiflexion with no weakness. He diagnosed her with probable left sciatica, and prescribed Bextra 10 mg once daily and 90 mg of Kenalog intramuscular for radicular pain. He scheduled a follow-up exam in one week, but advised her that if her symptoms were resolving, she could cancel the appointment. (R. 289)

Krowiorz returned to the clinic on September 9, 2002, and was given what appears to be another injection of Kenalog. (R. 288) In addition, at Krowiorz's request, Dr. Johnson increased her nighttime dosage of Methadone to 20 mg. (R. 287) Krowiorz sought a refill of her Methadone three days early, and the doctor wrote her a refill order

for September 20, 2002. (R. 286) Her prescription was refilled again on October 20 and November 20, 2002. (R. 283-84)

Krowiorz went to the ER on November 27, 2002, complaining of right leg pain with no new injury. (R. 264-69) She asked for a cortisone shot, and stated she had tried to see Dr. Johnson before going to the hospital but could not get in until December 5, 2002. Krowiorz refused any narcotic pain relievers "due to [her] oral contract with Dr. Johnson" regarding her medications. (R. 265) The ER doctor diagnosed her with sciatica, and prescribed a Prednisone burst. (R. 269)

Krowiorz returned to the ER on November 29, 2002, still complaining of right leg pain. (R. 270-76) She rated her pain as 8 on a scale of 10. She was treated with Toradol and I.V. Demerol in the hospital. An X-ray of her lumbosacral spine revealed "[s]ome disc narrowing at two levels with mild spinal curvature, renal artery stent, and cholecystectomy clips." (R. 276) The doctor increased her Methadone dosage to a maximum of 80 mg daily, and informed Dr. Johnson of the increase. (R. 275)

On December 5, 2002, Krowiorz saw Dr. Johnson for follow-up of her "continued pain of a radicular nature" and "chronic back pain." (R. 282) Dr. Johnson noted Krowiorz was, at that time, on Methadone 90 mg daily. She stated the ER doctors had started her on steroids but she only took them for two days because they kept her from sleeping. The doctor wanted to order an MRI but noted Krowiorz had no health insurance. He planned to see if she could obtain assistance through another source, and then see her again after the MRI. (*Id.*)

Dr. Johnson saw Krowiorz again on December 16, 2002. She continued to have symptoms but could not afford an MRI. Krowiorz stated she would see if she could get county assistance to go to Iowa City for the MRI. She continued to take Methadone at a dosage of "10 mg four in the morning and five in the evening." (R. 281)

On January 27, 2003, Dr. Johnson wrote an updated opinion letter regarding Krowiorz's condition. He indicated he continued to treat her for chronic pain syndrome, and stated her back and leg pain were "very debilitating." (R. 279) He noted her symptoms were controlled with long-term chronic pain therapy, but she remained debilitated and unable to do any significant work. He stated she was "on an aggressive pain management regimen that includes Methadone." (*Id.*)

On February 18, 2003, Krowiorz was seen for follow-up of "sciatica, hypertension, depression, and back pain." (R. 318) She rated her back pain "as 2 or 3 out of 10 on the methadone." (*Id.*) The doctor noted Krowiorz's back pain was "improved." (R. 319)

At a follow-up exam on April 1, 2003, Krowiorz told William J. Riesen, M.D. that her back pain was "well controlled," and she had "no exacerbating positions or activities." (R. 316) She reported "slight bilateral extremity swelling when she [sat] on the floor or edge of a chair." (*Id.*) He noted she was ambulatory and "move[d] about without difficulty." (*Id.*) He noted her chronic sciatic pain was "controlled on current program," and he continued her Methadone dosage.(*Id.*)

On April 11, 2003, Krowiorz was seen by a physician's assistant at her doctor's office with complaints of acute left hand swelling and pain. She stated her hand felt warm and hurt, and she had no grip strength, but she had no numbness or tingling. Examination revealed marked swelling of her hand "over the metatarsophalangeal joint of the left thumb and into the dorsum of the left hand at around the index finger." (R. 315) The hand was noted to be warm, tender to palpation, and exhibiting limited range of motion and some weakness. Range of motion was tender but normal; grip strength was slightly weak on the left; pulses and neurologic status were normal. She was diagnosed with "gout or pseudogout," without ruling out the possibility of infection. She was scheduled

for a hand X-ray and lab studies, and was started on antibiotics and a nonsteroidal anti-inflammatory, and a follow-up was scheduled. (*Id.*)

At a follow-up visit on April 14, 2003, Krowiorz's hand was much improved. She stated she had been unable to afford the prescribed antibiotic, and the pharmacist had given her one day's worth. She had no pain or swelling and no new complaints. Notes indicate her "X-rays showed degenerative disk disease but her elevated white count did suggest cellulitis." (R. 313) The physician's assistant's impression was "[a]pparent resolution of what probably was a cellulitic process." (*Id.*) She gave Krowiorz some antibiotic samples to use and told her to follow up with Dr. Johnson. (*Id.*)

Krowiorz received an early refill of her Methadone on April 25, 2003, because she stated she was going to Minnesota to visit "for a couple of months." (R. 312) On May 12, 2003, she returned to see the physician's assistant, reporting that her Methadone prescription was stolen the previous Wednesday, and she had gone to the ER on Saturday night with withdrawal symptoms. (R. 311; *see* R. 297) The P.A. noted Krowiorz had "never reported a prescription missing or stolen before." (R. 311) She refilled the prescription with enough to last until Krowiorz's June 2, 2003, appointment with Dr. Johnson. (*Id.*)

Krowiorz saw the physician's assistant again on May 27, 2003, with complaints of fluid retention in both of her legs. The P.A. noted this probably was "secondary to salt indiscretion." (R. 309) She prescribed Lasix. She also refilled Krowiorz's methadone prescription to last until June 23, 2003, because Krowiorz stated her aunt had died and she was going to Minnesota to spend a few weeks with her mother. (R. 309-10)

Krowiorz saw Dr. Johnson again on July 1, 2003, for follow-up. She did not report any new symptoms or problems with her back. The doctor reiterated their verbal contract about her medication use, and Krowiorz continued to maintain her innocence in

the matter of her stolen medication. The doctor indicated they had reported the incident to the Mason City Police Department. He refilled her Methadone and other medications. (R. 307)

Krowiorz received a Methadone refill on July 21, 2003, to last until August 30, 2003. (R. 306) She saw Dr. Johnson for follow-up on July 31, 2003, and reported her energy level was improving. He noted her chronic back pain was being treated with Methadone. (R. 305)

Krowiorz requested an early refill of her Methadone on both August 18 and 19, 2003. The physician's assistant told her she could pick up her refill prescription on August 21, 2003, and it would not be refilled until September 21, 2003. She noted Krowiorz was "somewhat agitated" because the refill was declined at that time. (R. 304)

d. Depression

Although Krowiorz did not indicate, in her initial application, that she was disabled due to mental problems, she has sought treatment for depression and she testified regarding her depressive symptoms during the hearing. She saw J.A. Jackson, M.D. on May 15, 2001, for a psychiatric intake examination. Dr. Jackson noted Krowiorz was well known to him, and she had "an extensive past history of alcohol dependence." (R. 210) He diagnosed her with alcohol dependence in full sustained remission, and major depression, recurrent, with a GAF of 25, indicating an inability to function in most areas. *See* DSM-IV at 32. Prozac apparently had been prescribed by Krowiorz's family doctor (*see* R. 241), and Dr. Jackson increased her Prozac dosage to 40 mg. He also added Remeron 30 mg and Seroquel 100 mg, and he directed her to return for follow-up in one month. (*Id.*)

Krowiorz failed to appear for an appointment with Dr. Jackson on June 25, 2001. (R. 209) At her next appointment on July 18, 2001, she reported continuing anxiety, and opined the Seroquel was increasing her anxiety. Dr. Jackson noted Krowiorz's insight and judgment were fair, her impulsivity was low, and her frustration tolerance was adequate. He indicated she had intact memory, a good ability to abstract, good concentration, and average intelligence, with a GAF of 45, indicating serious symptoms or a serious impairment in social or occupational functioning. *See* DSM-IV at 32. He gave her a prescription for Diazepam 10 mg twice daily, and some samples of Prozac. (R. 208)

Krowiorz returned for follow-up on July 25, 2001. She asked Dr. Jackson to discontinue the Diazepam and prescribe Alprazolam in its place. He was reluctant to do so based on "the markedly greater addi[c]tion potential of Alprazolam." (R. 207) Krowiorz's diagnosis remained unchanged, and the doctor did not change any of her medications. He scheduled a follow-up appointment for her in October 2001. (*Id.*)

There are no further record entries regarding treatment by a psychiatrist or psychologist. However, at a DDS consultative examination on September 13, 2001, Krowiorz reported she was being treated for depression by Dr. Jackson. She stated her mood had been stable and she was doing well, and the consultative physician found her depression to be under good control. (R. 219, 221)

Dr. Johnson saw Krowiorz on February 18, 2003, for follow-up of her depression and medical complaints. He noted her "despondency [was] much improved" on Lexapro and she was tolerating the drug well. (R. 318)

On July 1, 2003, Krowiorz saw Dr. Johnson for follow-up of her various conditions. He noted her affect was anxious but she was "oriented times three." (R. 308)

She did not report new symptoms and he noted her anxiety with depression was being treated. (*Id.*)

The next evidence of any mental health treatment received by Krowiorz is a chemical dependency evaluation on July 7, 2003. Krowiorz went to the hospital stating she had run out of her Methadone. She was exhibiting withdrawal symptoms, and she was hospitalized overnight and placed on Librium and Mellaril. Her mood stabilized. She was diagnosed with Methadone dependence and major depression, recurrent, moderate. (R. 297-302) The record indicates that for several weeks leading up to this hospitalization, Krowiorz had sought early refill of her Methadone from at least two doctors. She denied abusing the medication, maintaining her medication had been stolen. A physician's assistant noted this was the first evidence of possible noncompliance in two years, and Krowiorz had "been very reasonable with the handling of her methadone and . . . very responsible." (R. 311; *see* R. 304) She was cautioned that her prescriptions would be monitored very closely and if she ran out of medication early, she would have to go without; her prescription would not be refilled early. (R. 307-08)

e. Consultative evaluations

On September 13, 2001, Krowiorz was examined by Jon R. Yankey, M.D. at the request of Disability Determination Services. (R. 218-23) Based on Krowiorz's subjective complaints and his examination, the doctor assessed her as having chronic low back pain, a history of "degenerative arthritis" in her back, a history of breathing difficulties, depression, and high blood pressure. (R. 220) He noted she had not had any X-rays or an MRI of her back to substantiate a diagnosis of degenerative arthritis. He found her symptoms to be "mild to moderate," with minimal physical findings. (R. 221) He similarly found her breathing difficulties to be mild, with "essentially negative"

physical findings. (*Id.*) He noted her depression and high blood pressure both seemed to be under good control. He found she would be mildly restricted in lifting and carrying, but she would not be significantly restricted for sitting, standing, moving about, walking, climbing, stooping, kneeling, crawling, handling objects, seeing, hearing, speaking, traveling, or work environment. (*Id.*)

Dennis A. Weis, M.D. reviewed the file and Dr. Yankey's examination report on December 17, 2001, and concurred in Dr. Yankey's findings. (R. 243) John A. May, M.D. reviewed the file on May 29, 2002, and similarly concurred in the prior assessment. (*Id.;* R. 247)

On November 30, 2001, Carole Kazmierski, Ph.D. completed a Psychiatric Review Technique form after reviewing Krowiorz's records. (R. 227-40) She found Krowiorz's history to be positive for an affective disorder ("MDD"; *see* R. 230), and a substance addiction disorder, in full, sustained remission. (R. 235) She opined Krowiorz would be moderately limited in maintaining concentration, persistence, or pace; and mildly restricted in the activities of daily living and maintaining social functioning. (R. 237)

Dr. Kazmierski arrived at the following Residual Mental Functional Capacity Assessment. (R. 224-26) She found Krowiorz's mental impairments to be "major depressive disorder and alcohol dependence in full sustained remission." (R. 241) She found these impairments to be severe, but not at the listing level, and she found Dr. Jackson's GAF ratings "appear[ed] low given claimant's symptomatology." (*Id.*) She found Krowiorz would be moderately limited in her ability to understand, remember, and carry out detailed instructions; maintain attention and concentration for extended periods; complete a normal workday and work week without interruption from psychologically-based symptoms; and perform at a consistent pace without an

unreasonable number and length of rest periods. (R. 224-25) She found Krowiorz to have no other limitations in functioning due to mental impairments. (*Id.*; R. 242)

On April 30, 2002, Steven B. Mayhew, Ph.D. saw Krowiorz for a psychological disability examination. He noted Krowiorz was "believed to be a good historian, providing adequate and consistent information." (R. 245) She stated she had difficulty staying asleep, she found herself eating often even when she was not hungry, she felt angry all the time, and she experienced stress from residing with her daughter and from being unemployed. She stated she had experienced anxiety and depression for "several years." (*Id.*) Dr. Mayhew noted Krowiorz was cooperative during the evaluation and her mood was composed with an appropriate affect. He observed no physical problems in her gait or behavior during the interview. Dr. Mayhew found no apparent functional impairment or limitation in Krowiorz's ability to read, do laundry, prepare meals, and meet her own transportation needs. He reached the following additional conclusions:

> Cynthia's capacity to understand, retain, and follow work-related instructions and procedures is considered unimpaired. Cynthia's capacity to sustain attention, concentration, and reasonable pace at entry-level work-like tasks is estimated to be variable but not significantly limited. Cynthia's capacity to interact appropriately with supervisors, co-workers, and the general public is considered mildly impaired and may work best in settings with limited contact with co-workers or the public. Cynthia's capacity to tolerate stress and pressure of simple, unskilled work, and to respond appropriately is estimated to be moderately limited. Exercising reasonable judgment or tolerance of stress in the work-place may be a problem. If Cynthia is determined eligible for benefits, she would appear capable of managing them without assistance.

(R. 246)

On May 29, 2002, Philip R. Laughlin, Ph.D. reviewed the record and completed a Psychiatric Review Technique form. He found Krowiorz would be moderately limited in her ability to maintain concentration, persistence, and pace; and mildly restricted in her activities of daily living and maintaining social functioning. (R. 251-62) Dr. Laughlin arrived at the following Residual Mental Functional Capacity Assessment. (R. 248-50) He found Krowiorz would be moderately limited in her ability to understand, remember, and carry out detailed instructions; maintain attention and concentration for extended periods; perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances; complete a normal workday and work week without interruptions from psychologically based symptoms; perform at a consistent pace without an unreasonable number and length of rest periods; and respond appropriately to changes in the work setting. He found she had no other limitations in her mental work-related abilities. (*Id.*) In his review summary, Dr. Laughlin noted the record contained no evidence of any follow-up mental health care since her last assessment, and neither Krowiorz nor her daughter reported any further deterioration in Krowiorz's activities of daily living since the prior assessment. (R. 263)

4. Vocational expert's testimony

The ALJ asked VE Roger Marquardt the following hypothetical question:

> I'd like you to consider a 56-year-old with a twelfth grade education, with additional education as a nurse aide and as a medication aide. She alleges severe debilitating back problems, however, there is absolutely nothing in the record, no objective evidence in the record, to indicate that she has any pathological back problems. She was examined at the request of the Social Security Administration by Dr. Yankey in September of 2001, and he found deep tendon reflexes active and symmetrical in the arms, triceps, biceps, and in the

> legs, knees, and ankles. Sensation to light touch and pinprick intact in the arms and legs bilaterally. Strength, including grips, was full and symmetrical in the arms. She was able to heel and toe walk and do squats, as well. She was able to tandem walk without difficulty. Finger to nose test was negative. Gait was normal. . . . Consequently, because there is nothing in the record except her subjective complaints, and there are numerous inconsistencies in this record. She testified today that she can only walk a half a block. However, in the record . . ., she said she can walk 30 minutes. She said she can only sit 10 to 15 minutes, yet she's been sitting here almost an hour. She said she can only stand for 10 to 15 minutes, however, again I indicate that she said she can walk for 30 minutes. You have to stand in order to walk. She said she can only lift 10 lbs. but there's nothing objective in the record that would limit her to the lifting of 10 lbs. Therefore, in terms of her physical functional capacity, it would appear that she should be able to at least occasionally lift 40 lbs., frequently lift 25 lbs. That she should have no problem sitting, standing, walking, bending, stooping, climbing, crawling, kneeling, and crouching. She has no environmental [or] communicative limitations. In terms of her alleged mental problems, she testified at the hearing that she has no difficulty basically with any significant depression, and I think the record supports that. The only problem she had was abuse of filling many prescription medications, apparently with drug-seeking behavior, which she claims at this point is under control Yet, she's still on the Methadone for some strange reason. With those restrictions, would she be able to perform any of her past work activity?

(R. 352-54)

The VE responded that the hypothetical claimant would be able to return to Krowiorz's past relevant work as a housekeeper/cleaner and a fast food worker. The nursing aide job would be eliminated due to the lifting limitations. However, the VE opined the claimant would have transferable skills from that job in terms of providing

proper personal care and monitoring of others. Jobs in which those skills would be useful include child care provider, either in a private home or a daycare center, and first aid attendant, for example at an elementary school, industrial center, or manufacturing plant. (R. 354-55) She also could work as a home companion who runs errands for an individual, cooks meals, cares for their clothes, and the like. (R. 355) The VE indicated all of these jobs would be classified as light work activity. (R. 356)

According to the VE, if the claimant was limited to standing for only ten to fifteen minutes at a time, she would not be able to perform any of Krowiorz's past relevant work or any of the other jobs listed by the VE. If she was limited to sitting for half an hour, with the need to be able to change positions at will, that would not affect her ability to perform her past work because those jobs did not require prolonged sitting. If the claimant was limited to walking no more than a block before taking a half-hour break, she would not be able to perform Krowiorz's past work. (R. 356-57)

If the claimant could only work at a slow pace, as described by Krowiorz, she would be unable to perform any of the jobs listed by the VE "at a competitive level." (R. 357) If her contact with others was limited due to irritability, and she could have only limited contact with the public, the VE opined the claimant still could work as a cleaner or housekeeper. (*Id.*) If she had to shift positions every fifteen to twenty minutes, the VE opined the claimant could still work as a personal companion, but she could not return to any of her past work. (R. 358)

5. The ALJ's decision

The ALJ found Krowiorz's work after her alleged disability onset date was not substantial gainful activity. (R. 28) However, she noted Krowiorz's "work is an indication of her involvement in a range of daily activity not consistent with disability

from all past relevant work or from jobs existing in significant numbers in the national economy." (*Id.*) She found Krowiorz retained the residual functional capacity to do her past relevant work, and further could make the vocational adjustment to other unskilled work. (R. 27)

The ALJ found Krowiorz's subjective allegations of chronic, debilitating pain not to be credible for several reasons. Regarding Krowiorz's breathing problems, the ALJ noted Krowiorz had continued to smoke despite repeated advice by her doctors that she should quit. She found Krowiorz's "failure to stop smoking significantly undermines [the ALJ's] willingness to credit her allegations." (R. 29)

Regarding Krowiorz's alleged disability due to back pain, the ALJ pointed to the lack of objective medical evidence in the file to substantiate Krowiorz's testimony. The ALJ relied on Dr. Yankey's observation that Krowiorz's treating physician, Dr. Johnson, had declared Krowiorz disabled without offering any "positive physical findings to substantiate significant lumbar disease." (R. 30) Although Dr. Johnson's letters were "quite favorable to the claimant," the ALJ did not give his opinion controlling weight because she found his opinions were "not well supported by objective signs and laboratory findings." (*Id.*; *see also* R. 30-31)

The ALJ also discounted Krowiorz's credibility because she found Krowiorz "had not been completely forthright in providing information to others, including her treating doctor." (R. 31) She noted Krowiorz had indicated at one point that she quit working as a medication aide because she kept falling asleep, but she told her treating doctor she quit working because of the pain from standing, bending, and stooping. (*Id.*) The ALJ also found Krowiorz's "medication seeking behavior is consistent with exaggeration of complaints for purposes of obtaining medications for abuse rather than merely for pain

relief. The repeated lack of objective evidence of serious pathology to support her allegations is likewise consistent with this view." (R. 32)

The ALJ also gave little weight to Dr. Jackson's assessment of Krowiorz's GAF, relying instead on the state agency consultant's opinion that those GAF ratings were "low or inconsistent with the claimant's symptomatology." (R. 33-34) The ALJ noted Krowiorz had told the consultive physician her depression was under good control and she was doing well. (R. 34) The ALJ gave some weight to the opinions of the examining psychologists who found Krowiorz could have a problem with undue stress and interactions with others, but the ALJ did not find the psychologists' opinions supported the ultimate finding that Krowiorz would be precluded from performing all types of work. (*Id.*)

The ALJ gave little weight to the testimony of Krowiorz's daughter, noting the daughter has a financial interest in seeing her mother obtain benefits. The ALJ also found inconsistencies between the daughter's statements about her mother's abilities and Krowiorz's statements about her activities. For example, she noted, "The daughter testified at the hearing that her mother can hardly walk and cannot lift anything. Nonetheless the claimant walks everyday at the grocery store and carries things back to her living place." (*Id.*)[3]

The ALJ found Krowiorz's poor work history detracted from her credibility, noting she had only earned over $6,000 during five years of her work history. (*Id.*)

The ALJ found Krowiorz's hearing testimony that medications make her pain tolerable to be inconsistent with her allegation that her pain is severe and work-

[3]The court notes Krowiorz did not testify she walks across the street to the grocery store, and then "carries things back to her living place." She stated the grocery store is right across the street so she only buys small amounts of food at a time to keep from having to walk around the store for very long. There is no evidence that Krowiorz walks, rather than drives, to the grocery store.

precluding. The ALJ further found no evidence that any side effects from Krowiorz's medications have been shown to exist for a continuous twelve-month period. (R. 34-35)

From her review of the record, her assessment that Krowiorz's subjective complaints were not credible, and her reliance on the opinions of the consultative physicians', the ALJ determined that Krowiorz retains "the residual functional capacity to perform the physical exertional and nonexertional requirements of work except for lifting more than 40 pounds occasionally and 25 pounds frequently. She would have no problem sitting, standing, walking, bending, stooping, climbing, crawling, kneeling, or crouching," and would have no environmental limitations. (R. 35)

Based on this RFC and the VE's testimony, the ALJ concluded Krowiorz could return to and perform her past relevant work as a housekeeping cleaner and fast food worker. (*Id.*) The ALJ also noted the burden had been shifted to the Commissioner to prove "the existence of other jobs an individual defined as closely approaching advanced age and as a person of advanced age could perform like the claimant consistent with her 8th grade education[4] and additional training as a certified nurse aide [and] certified medication aide, her past relevant work history and residual functional capacity." (*Id.*) The ALJ found this burden was satisfied by the VE's hearing testimony. (*Id.*) The ALJ found Krowiorz could make a vocational adjustment to other jobs that exist in significant numbers, including child care provider, first aid attendant, and companion. (R. 35-36) The ALJ specifically found her hypothetical question to the VE was consistent with both the objective and the subjective evidence of record, and the VE's answer to the

[4]This notation regarding Krowiorz's education appears to be a transcriptional error. Krowiorz testified she completed high school (R. 324), and the ALJ made a finding that Krowiorz had "a 12th grade education with additional training as a nurse aide and medication aide[.]" (R. 37, ¶ 9)

hypothetical question was "consistent with the claimant's profile as to age, education, previous work experience and residual functional capacity." (R. 36)

Despite the ALJ's finding that the record lacked sufficient medical evidence to support Krowiorz's disability claim, the ALJ nevertheless found Krowiorz to have "severe impairments in combination which include degenerative arthritis and disc narrowing at two levels with complaints of pain, hypertension generally controlled by medication and history of angioplasty of the renal artery with placement of stent, history of depression and medications seeking with distant history of alcohol abuse[.]" (R. 36, ¶ 3) She further found Krowiorz's impairments not to meet the requirements of the Listings. (*Id.*)

For all of the above reasons, the ALJ found Krowiorz not to be disabled. (R. 36, 37)

III. DISABILITY DETERMINATIONS, THE BURDEN OF PROOF, AND THE SUBSTANTIAL EVIDENCE STANDARD

A. Disability Determinations and the Burden of Proof

Section 423(d) of the Social Security Act defines a disability as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. § 423(d)(1)(A); 20 C.F.R. § 404.1505. A claimant has a disability when the claimant is "not only unable to do his previous work but cannot, considering his age, education and work experience, engage in any other kind of substantial gainful work which exists . . . in significant numbers either in the region where such individual lives or in several regions of the country." 42 U.S.C. § 432(d)(2)(A).

To determine whether a claimant has a disability within the meaning of the Social Security Act, the Commissioner follows a five-step sequential evaluation process outlined in the regulations. 20 C.F.R. §§ 404.1520 & 416.920; *Dixon v. Barnhart*, 353 F.3d 602, 605 (8th Cir. 2003); *Kelley v. Callahan*, 133 F.3d 583, 587-88 (8th Cir. 1998) (citing *Ingram v. Chater*, 107 F.3d 598, 600 (8th Cir. 1997)). First, the Commissioner will consider a claimant's work activity. If the claimant is engaged in substantial gainful activity, then the claimant is not disabled. 20 C.F.R. § 404.1520(4)(i).

Second, if the claimant is not engaged in substantial gainful activity, the Commissioner looks to see "whether the claimant has a severe impairment that significantly limits the claimant's physical or mental ability to perform basic work activities." *Dixon*, 353 F.3d at 605; *accord Lewis v. Barnhart*, 353 F.3d 642, 645 (8th Cir. 2003). The United States Supreme Court has explained:

> The ability to do basic work activities is defined as "the abilities and aptitudes necessary to do most jobs." . . . Such abilities and aptitudes include "[p]hysical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling"; "[c]apacities for seeing, hearing, and speaking"; "[u]nderstanding, carrying out and remembering simple instructions"; "[u]se of judgment"; "[r]esponding appropriately to supervision, co-workers, and usual work situations"; and "[d]ealing with changes in a routine work setting."

Bowen v. Yuckert, 482 U.S. 137, 140-42, 107 S. Ct. 2287, 2291, 96 L. Ed. 2d 119 (1987) (citing 20 C.F.R. §§ 404.1521(b), 416.921(b)).

Third, if the claimant has a severe impairment, then the Commissioner will consider the medical severity of the impairment. If the impairment meets or equals one of the presumptively disabling impairments listed in the regulations, then the claimant is

considered disabled, regardless of age, education, or work experience. 20 C.F.R. § 404.1520; *Kelley*, 133 F.3d at 588.

Fourth, if the claimant's impairment is severe, but it does not meet or equal one of the presumptively disabling impairments, then the Commissioner will assess the claimant's residual functional capacity ("RFC") to determine the claimant's "ability to meet the physical, mental, sensory, and other requirements" of the claimant's past relevant work. 20 C.F.R. §§ 404.1520(4)(iv); 404.1545(4); *see Lewis*, 353 F.3d at 645-46 ("RFC is a medical question defined wholly in terms of the claimant's physical ability to perform exertional tasks or, in other words, 'what the claimant can still do' despite his or her physical or mental limitations.") (citing *Bradshaw v. Heckler*, 810 F.2d 786, 790 (8th Cir. 1987); 20 C.F.R. § 404.1520(e) (1986)); *Dixon*, *supra*. The claimant is responsible for providing evidence the Commissioner will use to make a finding as to the claimant's RFC, but the Commissioner is responsible for developing the claimant's "complete medical history, including arranging for a consultative examination(s) if necessary, and making every reasonable effort to help [the claimant] get medical reports from [the claimant's] own medical sources." 20 C.F.R. § 404.1545(3). The Commissioner also will consider certain non-medical evidence and other evidence listed in the regulations. *See id.* If a claimant retains the RFC to perform past relevant work, then the claimant is not disabled. 20 C.F.R. § 404.1520(4)(iv).

Fifth, if the claimant's RFC as determined in step four will not allow the claimant to perform past relevant work, then the burden shifts to the Commissioner "to prove that there is other work that [the claimant] can do, given [the claimant's] RFC [as determined at step four], age, education, and work experience." Clarification of Rules Involving Residual Functional Capacity Assessments, etc., 68 Fed. Reg. 51,153, 51,155 (Aug. 26, 2003). The Commissioner must prove not only that the claimant's RFC will allow the

claimant to make an adjustment to other work, but also that the other work exists in significant numbers in the national economy. *Id.*; 20 C.F.R. § 404.1520(4)(v); *Dixon, supra*; *Pearsall v. Massanari*, 274 F.3d 1211, 1217 (8th Cir. 2001) ("[I]f the claimant cannot perform the past work, the burden then shifts to the Commissioner to prove that there are other jobs in the national economy that the claimant can perform.") (citing *Cox v. Apfel*, 160 F.3d 1203, 1206 (8th Cir. 1998)); *Nevland v. Apfel*, 204 F.3d 853, 857 (8th Cir. 2000). If the claimant can make an adjustment to other work that exists in significant numbers in the national economy, then the Commissioner will find the claimant is not disabled. If the claimant cannot make an adjustment to other work, then the Commissioner will find the claimant is disabled. 20 C.F.R. § 404.1520(r)(v).

B. The Substantial Evidence Standard

The court reviews an ALJ's decision to determine whether the ALJ applied the correct legal standards, and whether the factual findings are supported by substantial evidence on the record as a whole. *Hensley v. Barnhart*, 352 F.3d 353, 355 (8th Cir. 2003); *Banks v. Massanari*, 258 F.3d 820, 823 (8th Cir. 2001) (citing *Lowe v. Apfel*, 226 F.3d 969, 971 (8th Cir. 2000)); *Berger v. Apfel*, 200 F.3d 1157, 1161 (8th Cir. 2000) (citing 42 U.S.C. § 405(g); *Richardson v. Perales*, 402 U.S. 389, 401, 91 S. Ct. 1420, 28 L. Ed. 2d 842 (1971)). This review is deferential; the court must affirm the ALJ's factual findings if they are supported by substantial evidence on the record as a whole. *Id.* (citing *Estes v. Barnhart*, 275 F.3d 722, 724 (8th Cir. 2002); *Krogmeier v. Barnhart*, 294 F.3d 1019, 1022 (8th Cir. 2002) (citing *Prosch v. Apfel*, 201 F.3d 1010, 1012 (8th Cir. 2000)); *Kelley v. Callahan*, 133 F.3d 583, 587 (8th Cir. 1998) (citing *Matthews v. Bowen*, 879 F.2d 422, 423-24 (8th Cir. 1989)); 42 U.S.C. § 405(g) ("The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall

be conclusive. . . ."). Under this standard, "[s]ubstantial evidence is less than a preponderance but is enough that a reasonable mind would find it adequate to support the Commissioner's conclusion." *Krogmeier, id.*; *Weiler v. Apfel*, 179 F.3d 1107, 1109 (8th Cir. 1999) (citing *Pierce v. Apfel*, 173 F.3d 704, 706 (8th Cir. 1999)); *accord Gowell v. Apfel*, 242 F.3d 793, 796 (8th Cir. 2001) (citing *Craig v. Apfel*, 212 F.3d 433, 436 (8th Cir. 2000)); *Hutton v. Apfel*, 175 F.3d 651, 654 (8th Cir. 1999); *Woolf v. Shalala*, 3 F.3d 1210, 1213 (8th Cir. 1993).

Moreover, substantial evidence "on the record as a whole" requires consideration of the record in its entirety, taking into account both "evidence that detracts from the Commissioner's decision as well as evidence that supports it." *Krogmeier*, 294 F.3d at 1022 (citing *Craig*, 212 F.3d at 436); *Willcuts v. Apfel*, 143 F.3d 1134, 1136 (8th Cir. 1998) (quoting *Universal Camera Corp. v. N.L.R.B.*, 340 U.S. 474, 488, 71 S. Ct. 456, 464, 95 L. Ed. 456 (1951)); *Gowell*, 242 F.3d at 796; *Hutton*, 175 F.3d at 654 (citing *Woolf*, 3 F.3d at 1213); *Kelley*, 133 F.3d at 587 (citing *Cline v. Sullivan*, 939 F.2d 560, 564 (8th Cir. 1991)). The court must "search the record for evidence contradicting the [Commissioner's] decision and give that evidence appropriate weight when determining whether the overall evidence in support is substantial." *Baldwin v. Barnhart*, 349 F.3d 549, 555 (8th Cir. 2003) (also citing *Cline*, *supra*).

In evaluating the evidence in an appeal of a denial of benefits, the court must apply a balancing test to assess any contradictory evidence. *Sobania v. Secretary of Health & Human Serv.*, 879 F.2d 441, 444 (8th Cir. 1989) (citing *Steadman v. S.E.C.*, 450 U.S. 91, 99, 101 S. Ct. 999, 1006, 67 L. Ed. 2d 69 (1981)). The court, however, does not "reweigh the evidence presented to the ALJ," *Baldwin*, 349 F.3d at 555 (citing *Bates v. Chater*, 54 F.3d 529, 532 (8th Cir. 1995)), or "review the factual record *de novo*." *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996) (citing *Naber v. Shalala*, 22 F.3d 186, 188

(8th Cir. 1994)). Instead, if, after reviewing the evidence, the court finds it "possible to draw two inconsistent positions from the evidence and one of those positions represents the agency's findings, [the court] must affirm the [Commissioner's] decision." *Id.* (quoting *Robinson v. Sullivan*, 956 F.2d 836, 838 (8th Cir. 1992), and citing *Cruse v. Bowen*, 867 F.2d 1183, 1184 (8th Cir. 1989)); *accord Baldwin*, 349 F.3d at 555; *Young v. Apfel*, 221 F.3d 1065, 1068 (8th Cir. 2000). This is true even in cases where the court "might have weighed the evidence differently." *Culbertson v. Shalala*, 30 F.3d 934, 939 (8th Cir. 1994) (citing *Browning v. Sullivan*, 958 F.2d 817, 822 (8th Cir. 1992)); *accord Krogmeier*, 294 F.3d at 1022 (citing *Woolf*, 3 F.3d at 1213). The court may not reverse the Commissioner's decision "merely because substantial evidence would have supported an opposite decision." *Baldwin*, 349 F.3d at 555 (citing *Grebenick v. Chater*, 121 F.3d 1193, 1198 (8th Cir. 1997)); *Young*, 221 F.3d at 1068; *see Pearsall*, 274 F.3d at 1217; *Gowell*, 242 F.3d at 796; *Spradling v. Chater*, 126 F.3d 1072, 1074 (8th Cir. 1997).

On the issue of an ALJ's determination that a claimant's subjective complaints lack credibility, the Sixth and Seventh Circuits have held an ALJ's credibility determinations are entitled to considerable weight. *See, e.g., Young v. Secretary of H.H.S.*, 957 F.2d 386, 392 (7th Cir. 1992) (citing *Cheshier v. Bowen*, 831 F.2d 687, 690 (7th Cir. 1987)); *Gooch v. Secretary of H.H.S.*, 833 F.2d 589, 592 (6th Cir. 1987), *cert. denied*, 484 U.S. 1075, 108 S. Ct. 1050, 98 L. Ed. 2d. 1012 (1988); *Hardaway v. Secretary of H.H.S.*, 823 F.2d 922, 928 (6th Cir. 1987). Nonetheless, in the Eighth Circuit, an ALJ may not discredit a claimant's subjective allegations of pain, discomfort or other disabling limitations simply because there is a lack of objective evidence; instead, the ALJ may only discredit subjective complaints if they are inconsistent with the record as a whole. *See Hinchey v. Shalala*, 29 F.3d 428, 432 (8th Cir. 1994); *see also Bishop v. Sullivan*,

900 F.2d 1259, 1262 (8th Cir. 1990) (citing *Polaski v. Heckler*, 739 F.2d 1320, 1322 (8th Cir. 1984)). As the court explained in *Polaski v. Heckler:*

> The adjudicator must give full consideration to all of the evidence presented relating to subjective complaints, including the claimant's prior work record, and observations by third parties and treating and examining physicians relating to such matters as:
>
> 1) the claimant's daily activities;
> 2) the duration, frequency and intensity of the pain;
> 3) precipitating and aggravating factors;
> 4) dosage, effectiveness and side effects of medication;
> 5) functional restrictions.

Polaski, 739 F.2d 1320, 1322 (8th Cir. 1984). *Accord Ramirez v. Barnhart*, 292 F.3d 576, 580-81 (8th Cir. 2002).

IV. ANALYSIS

The record does not contain substantial evidence to support Krowiorz's claim that she is disabled due to respiratory problems, hypertension, or depression. All of these impairments are well controlled by medication and none of them, either singly or in combination with each other or with Krowiorz's other physical problems, would prevent her from working.

The record is less clear with regard to her claim of disability from back and leg pain. The ALJ rejected Krowiorz's claim and discounted her credibility because of a lack of direct medical evidence or a specific diagnosis of a severe back problem. The ALJ rejected the opinions of Krowiorz's long-time treating physician, Dr. Johnson, for the same reason, relying instead on the opinions of the agency's consulting physician,

Dr. Yankey, who stated Dr. Johnson had declared Krowiorz to be disabled without offering any "positive physical findings to substantiate significant lumbar disease." (R. 30) The ALJ noted Dr. Johnson's opinion letters were "quite favorable to the claimant," but she discounted his opinions because she found they were "not well supported by objective signs and laboratory findings." (*Id.*; *see also* R. 30-31)

Krowiorz argues the ALJ erred in rejecting Dr. Johnson's opinion, and in failing to make a proper credibility analysis pursuant to *Polaski*. She notes that under *Polaski*, her subjective complaints may not be disregarded "'solely because the objective medical evidence does not fully support them.'" (Doc. No. 7, p. 8, quoting *Polaski*, 751 F.2d at 948) In *Polaski*, the Eighth Circuit directed courts to consider "all of the evidence presented relating to subjective complaints, including the claimant's prior work record, and observations by third parties and treating and examining physicians," relating to at least five separate areas of inquiry. *Polaski*, 751 F.2d at 948. The court will examine the *Polaski* factors, and the ALJ's treatment of them, to determine whether the ALJ reached an appropriate conclusion regarding Krowiorz's credibility.

A. Daily Activities

Krowiorz testified she lives in a small apartment. She does light dusting, heats up meals in the microwave, and rinses out her few dishes, but her daughter does all the vacuuming and laundry. Her activities are limited. She drives a few blocks to her daughter's home in the morning to wake her grandson for school. She goes across the street to the grocery store and does her own grocery shopping, but she only buys food a day at a time because she cannot walk around the store for very long. She has no trouble driving short distances, but limits herself to local driving around Mason City, Iowa. She

spends most of her day watching TV. She stated she has to change positions every ten to fifteen minutes due to pain.

Krowiorz's daughter confirmed that she does her mother's vacuuming, laundry, and other heavy chores. She stated her mother has difficulty walking and is unable to lift much of anything. She has observed her mother grunting due to pain when she walks, and her mother must pull herself along with a rail to climb the three steps leading into her daughter's kitchen.

The court finds these allegations to be consistent with Krowiorz's complaints to her physicians, and finds this factor weighs in Krowiorz's favor.

B. Duration, Frequency, and Intensity of Pain

Krowiorz testified her back pain is constant. She gets some relief from medication, but nothing completely removes the pain. Activity, including walking, makes the pain worse. She described the pain as sharp and heavy in her low back, radiating with sharp pain into her leg. She stated that when the pain is at its worst, even small movements are very painful. However, on February 18, 2003, Krowiorz rated her back pain at "2 or 3 out of 10 on the methadone." (R. 318)

The court finds Krowiorz's allegations regarding her pain to be consistent with the frequency, duration, and dosage of pain medications she has been prescribed. The court finds it unlikely that medical doctors would continue to prescribe serious narcotic medications to Krowiorz if they believed her to be malingering. Further, there are no notations in her medical records that her doctors disbelieved her complaints of ongoing pain.

However, the court further finds Krowiorz's pain, although not relieved completely, is maintained at a tolerable level on medication. Therefore, the court finds

this factor weighs against her claim that her pain is completely disabling. The court does not doubt that Krowiorz has a certain amount of constant pain, but that is not enough to prevent her from all types of work.

C. Precipitating and Aggravating Factors

The record contains no direct evidence of what precipitated Krowiorz's back pain, but she testified to physical requirements of her work as a nurse's aide and a motel housekeeper that could have contributed to her condition. As a nurse's aide, she had to lift and move patients, assisting them in and out of bed and wheelchairs. As a housekeeper, she had to push a heavy cart filled with supplies, do vacuuming, and bend frequently. She stated she had pain while she worked at these jobs, but it did not become bad enough for her to quit working altogether until August 2000.

The ALJ notes Krowiorz's work history was poor and she only earned over $6,000 during five years while she was working. The ALJ found this did not "add to the credibility of her allegations." (R. 34) Krowiorz argues the ALJ's statement is misleading. She points out that her most productive work years were the five years immediately preceding her alleged disability onset date, when she was trying to keep working despite her pain. (*See* Doc. No. 7, p. 9) The record indicates Krowiorz had a poor work history from 1987 through 1994, and little or no work history prior to 1987. She earned $5,786.77 in 1995; $10,610.79 in 1996; $12,509.89 in 1997; $18,110.06 in 1998; $12,587.48 in 1999; $8,549.74 in 2000; and $2,364.60 in 2001. It appears Krowiorz's back pain worsened in 2000 (*see* R. 172-73). Given her testimony that she had back pain, although not severe, prior to 2000, her work history from 1995 through 2001 supports her allegation that she attempted to continue working, but her as her condition worsened, her earnings declined and she finally quit working due to back pain.

The court credits Krowiorz's testimony that working at her past jobs aggravated her back pain. As a result, the court finds the ALJ erred in discounting the credibility of these allegations when posing a hypothetical question to the VE.

D. Dosage, Effectiveness, and Side Effects of Medication

The court touched on this factor earlier, in discussing the duration, frequency, and intensity of Krowiorz's pain. Her doctors have prescribed significant doses of narcotic medication to help control her pain. Krowiorz testified the medication helps her pain but never removes it; she is in pain constantly. Krowiorz testified the medications make her a bit drowsy. The ALJ found this to be inconsistent with Krowiorz's testimony that she drives short distances around town. However, Krowiorz did not testify the drowsiness from her medications was debilitating, nor did she testify to any other debilitating side effects from her medications. The court finds Krowiorz's testimony that her medications make her a bit drowsy does not detract from her credibility, but further finds that, with one exception, there is no evidence of serious side effects from her medications that would prevent her from working.

The one exception relates to the side effect noted by Krowiorz in her brief as "the addictiveness of the methadone." (Doc. No. 7, p. 11, citing R. 302). The record contains evidence that Krowiorz abused prescription medications for a period of time in 2000 and 2001. The record suggests she again may have begun having problems in May 2003, continuing until she was hospitalized in July 2003, when she ran out of Methadone and began to experience withdrawal symptoms. She was referred for a chemical dependency evaluation, and doctors found she met the DSM-IV criteria for opiate dependence. They recommended she work with a pain clinic in hopes she could stay off of Methadone. (*See* R. 302-12)

The court finds the addictive quality of Methadone, Ultram, and other narcotic pain medications represents a significant potential side effect from those medications that should be considered in connection with a full *Polaski* analysis. As a result, the court finds this factor weighs in Krowiorz's favor. Based on Krowiorz's history, the court finds the ALJ failed to conduct a thorough *Polaski* evaluation with regard to the addictiveness of Krowiorz's medications.

Further, the court finds the ALJ erred in failing to make a determination regarding whether Krowiorz's abuse of prescription medications is a contributing factor material to a determination of disability.

E. Functional Restrictions

The last *Polaski* factor to be examined concerns Krowiorz's functional restrictions. Krowiorz testified she can stand for ten to fifteen minutes at a time before she has to sit down. She can walk half a block to one block at a time before pain causes her to stop. She is able to bend, but can do so only with pain. She does not kneel because she believes she would be unable to get back up without assistance. She can open a door, lift a gallon of milk using one hand, and lift a small bag of groceries. She is unable to perform pushing and pulling activities, such as vacuuming. She cannot lift anything very heavy, and restricts herself to a small bag of groceries at one time. She can climb stairs slowly, if there is a railing she can use for support. Krowiorz's daughter confirmed these restrictions.

Krowiorz also stated she can only sit for ten to fifteen minutes at a time before she has to change positions. The ALJ noted Krowiorz was able to sit through the hearing, but the ALJ failed to acknowledge that during the hearing, Krowiorz's attorney noted on the record that his client had been shifting positions frequently in her chair, and she stated

she was in pain during the hearing. (*See* R. 337) She noted she becomes uncomfortable sitting regardless of the type of chair in which she is sitting. (*Id.*)

During his objective examination of Krowiorz, Dr. Yankey found her to have the following limitations: (1) shoulders -- mild restriction of range of motion on forward elevation, and slight restriction on abduction at 0 to 150 degrees; (2) elbow - very slight restriction of range of motion on flexion-extension; (3) wrist – very slight restriction of range of motion on dorsiflexion on the right, palmar flexion on both sides, slight radial deviation on the right, slight ulnar deviation on both sides, with full extension of the hands, no problems making a fist or performing fine manipulation, and normal grip strength; (4) knees – mild restriction of range of motion on flexion-extension on both sides; (5) hips – very slight limitation on forward flexion, abduction, and adduction; (6) ankle – moderate restriction on dorsi-flexion on both sides. (R. 222-23)

Significantly, Dr. Yankey's examination revealed no restriction on range of motion of Krowiorz's cervical spine, and only mild restriction of range of motion on lateral flexion of her lumbar spine. She exhibited no muscle weakness, walked with a normal gait without assistive devices, walked on her heels and toes, and exhibited no sensory or reflex loss. She also was able to squat. (R. 223)

Dr. Yankey concluded Krowiorz would be mildly restricted in lifting and carrying, but she would not be restricted significantly for sitting, standing, moving about, walking, climbing, stooping, kneeling, crawling, handling objects, seeing, hearing, speaking, traveling, or work environment. (R. 221)

Besides Dr. Yankey's consultative examination, there is little objective medical evidence in the record to support Krowiorz's claimed functional limitations. In September 2000, she was noted upon X-ray examination to have "[s]ome facet

arthropathy . . . at L5 bilaterally."[5] (R. 181) An X-ray of her lumbosacral spine in November 2002 revealed "[s]ome disc narrowing at two levels [L3-4 and L4-5] with mild spinal curvature" (R. 276), which Dr. Johnson summarized as showing "degenerative disk disease." (R. 313) In Dr. Johnson's examination of Krowiorz on September 5, 2002, she exhibited normal deep tendon reflexes, full dorsiflexion with no weakness, and negative straight leg raising. He noted she walked with a limp, favoring her left leg, and she sat in a chair with her left buttock off the chair and her main weight on her right. He diagnosed her with probable left sciatica. (R. 289)

The medical evidence of record does not support Krawiorz's claim that she is limited functionally to an extent that she cannot perform any type of work. Even Dr. Johnson's own examination notes support the ALJ's decision not to credit his unsupported opinions that Krowiorz is unable to perform any type of work due to debilitating back pain.

However, the court finds Krowiorz's testimony to be credible to the extent she is unable to return to her past relevant work. The evidence suggests her past work was an aggravating factor, and possibly a precipitating factor, in her impairment. Considering the evidence as a whole, the court finds the ALJ did not present a proper hypothetical question to the VE that fully described Krowiorz's abilities and impairments that are supported by the record as a whole. The VE's testimony, therefore, cannot constitute substantial evidence to support the ALJ's finding of no disability. *See, e.g.*, *Hinchey v. Shalala*, 29 F.3d 428, 432 (8th Cir. 1994); *Wiekamp v. Apfel*, 116 F. Supp. 2d. 1056, 1073-74 (N.D. Iowa 2000).

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[5]Arthropathy is defined as "any joint disease." *Dorland's Pocket Medical Dictionary*, 75 (23rd ed. 1982).

For the reasons discussed above, the court recommends the Commissioner's decision be reversed and this case be remanded for further consideration, with directions that the ALJ (1) present a proper hypothetical question to the VE that credits Krowiorz's testimony that her past jobs aggravated her condition, and considers the addictiveness of Krowiorz's medications as part of the *Polaski* analysis regarding her overall credibility; and (2) make a determination regarding whether Krowiorz's addiction to prescription medications is a contributing factor material to a determination of disability.[6]

V. CONCLUSION

For the reasons discussed above, **IT IS RESPECTFULLY RECOMMENDED**, unless any party files objections[7] to the Report and Recommendation in accordance with 28 U.S.C. § 636 (b)(1)(C) and Fed. R. Civ. P. 72(b), within ten (10) days of the service of a copy of this Report and Recommendation, that the Commissioner's decision

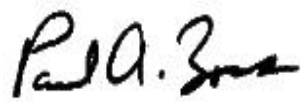
[6]Upon remand, the court also suggests the ALJ be directed to obtain further medical evidence regarding the condition of Krowiorz's back. The ALJ has a duty to develop the record fully and fairly, even when a claimant is represented by counsel. *Dozier v. Heckler*, 754 F.2d 274, 276 (8th Cir. 1985). The ALJ noted repeatedly that the record lacked sufficient medical evidence for the ALJ to determine the nature of Krowiorz's diagnosis regarding her back, yet the ALJ took no steps to obtain further medical evidence to assist her in evaluating Krowiorz's claim. Although it is Krowiorz's duty, in the first instance, to offer evidence in support of her claim, the ALJ nevertheless has an independent duty of inquiry "to scrupulously and conscientiously explore for all relevant facts." *Heckler v. Campbell*, 461 U.S. 458, 471 & n.1, 103 S. Ct. 1952, 1959 & n.1, 76 L. Ed. 2d 66 (1983) (Brennan, J., concurring) (citing *Broz v. Schweiker*, 677 F.2d 1351, 1364 (11th Cir. 1982). It would seem the ALJ could obtain further medical evidence short of ordering the MRI which the ALJ indicated she could not do.

[7]Objections must specify the parts of the report and recommendation to which objections are made. Objections must specify the parts of the record, including exhibits and transcript lines, which form the basis for such objections. *See* Fed. R. Civ. P. 72. Failure to file timely objections may result in waiver of the right to appeal questions of fact. *See Thomas v. Arn*, 474 U.S. 140, 155, 106 S. Ct. 466, 475, 88 L. Ed. 2d 435 (1985); *Thompson v. Nix*, 897 F.2d 356 (8th Cir. 1990).

bereversed, judgment be entered for the plaintiff, and this matter be remanded pursuant to sentence four of 42 U.S.C. § 405(g), for further proceedings consistent with this opinion.

IT IS SO ORDERED.

DATED this 30th day of March, 2005.



PAUL A. ZOSS
MAGISTRATE JUDGE
UNITED STATES DISTRICT COURT